Prescription Drug Claim Form

Anthem Prescription

Important: Please read instructions prior to completing.

Present your prescription drug card at the pharmacy to avoid having to submit a paper claim for reimbursement. If necessary, use this form for prescription claims that were purchased without using your drug card, or due to an emergency situation. You will be reimbursed directly for all covered services up to the allowed amount.

Instructions for Policyholders:

1. Complete all items in the top section for both the patient and policyholder.
2. Sign the form in the area provided.
3. Be sure to include the original cash receipt with this form, and make copies for your own records.
4. Have your pharmacist complete the bottom section of the form.
5. Fold the form, place in envelope, affix stamp, and mail it to the address below.
   Anthem Prescription Management
   PO Box 145433
   Cincinnati, OH 45250-5433
6. For a listing of participating pharmacies in your area, use our online pharmacy locator, refer to your member enrollment Network Chain Pharmacy List, or call your customer service area.

Instructions for Pharmacists:

1. Complete all items in the lower portion of this form.
2. Use a separate form for each patient.
3. Be sure to sign the form in the area provided.

If you have any questions, please call your Customer Service area.

Insurance Fraud Warning

It is unlawful to knowingly provide, false incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate state agency within the department of regulatory agencies.

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1. Policyholder or Insured Name _____
FIRST MIDDLE LAST

Address _____

City _____ State _____ Zip Code _____

2. Policyholder or Insured ID No. *(as shown on ID Card)* _____

3. Why was your insurance or drug card not used for this purchase? _____

4. Employer Name _____

5. Patient's Name _____
FIRST MIDDLE LAST

6. Patient's Birthdate _____/_____/_____ MM DD YY

7. Patient's Sex ☐ M ☐ F

8. Patient's Relationship to Policyholder:

☐ Self (Male) ☐ Self (Female) ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Other Male Dependent ☐ Other Female Dependent

9. Is the patient eligible for any other Prescription Drug Coverage? ☐ Yes ☐ No

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Anthem Prescription Management, LLC, its agent or representatives.

Signature _____ Date _____

Please ask your Pharmacist to fill out this section.

We cannot process this claim without the following information.

Fill out the information below or attach the original receipt to this form. No photocopies will be accepted.

Rx Number	Date Filled	Check	Metric quantity	Days supply	MD name / DEA Number	Is Rx		Rx Price (including tax)
1.		☐ New Rx ☐ Refill Rx				No DAW MD DAW Patient DAW RPh DAW No Generic	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	$
Reference number	Medication name, strength dosage form			Is drug compound Rx ☐	NDC number			
Rx Number	Date Filled	Check	Metric quantity	Days supply	MD name / DEA Number	Is Rx		Rx Price (including tax)
2.		☐ New Rx ☐ Refill Rx				No DAW MD DAW Patient DAW RPh DAW No Generic	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	$
Reference number	Medication name, strength dosage form			Is drug compound Rx ☐	NDC number			
Rx Number	Date Filled	Check	Metric quantity	Days supply	MD name / DEA Number	Is Rx		Rx Price (including tax)
3.		☐ New Rx ☐ Refill Rx				No DAW MD DAW Patient DAW RPh DAW No Generic	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	$
Reference number	Medication name, strength dosage form			Is drug compound Rx ☐	NDC number			

If more than three prescriptions, please fill out additional claim forms.

Pharmacy name Phone No. Street City State Zip

Pharmacist Must Fill Out

PHARMACY NABP ID No. Signature of pharmacist

NOTE: Payment for the above claim(s) will be made directly to the Policyholder. Any assignment of these benefits must include the signature of the Policyholder and is subject to the approval of Anthem Prescription Management, LLC

Please return completed form to the address shown in the instructions